Family Preservation Court Proposal

Introduction

The Riverside Superior Court's proposal for SAMHSA-CSAT Family Treatment Drug Court will bring together and improve three family drug courts that have been in operation for the past two years to create a "Family Preservation Court." The purpose of this proposal is to expand and enhance treatment services by ensuring immediate access to quality and culturally appropriate services necessary to build stronger family units, keep families together, and provide parents with the necessary tools to increase self-confidence and live a sober, healthy life style.

The three courts under the "Family Preservation Court" (AKA Family Treatment Drug Court) will target 360 drug-dependent clients who have been reported to the Department of Public Social Services (DPSS) Central Unit/"Differential Reponses" for reported neglect with a related substance abuse problem. The interventions proposed for this project include: Alternative Family Resolution (AFR) support, a 12 month substance abuse treatment; the Nurturing Families Program; life skills workshops; education and employment services; child development and school readiness workshops; case management services; social support services; follow-up services; and aftercare support. These proposed interventions are based on effective practices known to contribute to effective programs. A thorough evaluation will be conducted to examine overall program effectiveness and contribute to the growth of knowledge in the field.

Partners in this effort are Mental Health System (MHS) who will provide the intensive substance abuse treatment and support services; the Riverside County Mental Health and Substance Abuse Program will provide assessment, residential treatment and after care counseling; Department of Public Social Services (DPSS); will support the process by referring clients and offering Alternative Family Resolution (AFR) support services; Riverside Sheriff's Drug Endangered Children (DEC) will refer clients to FPC and provide children support services related to chemical exposure; and WestEd will be responsible for the implementation of the evaluation activities and adhere to the GPRA requirements. In addition, a total of thirteen members of various community and non-profit organizations are committed to expanding the Family Preservation Court (FPC) throughout Riverside County targeted areas. Four major objectives are proposed to integrate all of the required elements in this RFA. A logic model was carefully created to include strategies addressing chosen effective programs and best practices, research questions, required elements and proposed outcomes.

Section A. Statement of Need

1. Target population, Geographic Area to be Served and Justification of the Selection.

The Family Preservation Court's of the Riverside Superior Court proposes to target 360 "Prefiling" drug-dependent clients in three geographic areas in Riverside County; these include East Indio, Riverside Metro, and Southwest. The client and their children (3.5 average) will receive family intensive support services provided by Mental Health Systems, DPSS, DEC, and Community Outreach. "Pre-filing" is a case in which a parent is identified as having a substance abuse problem and is at risk of losing their child(ren) due to neglect. Eligibility for the FPC services include; 1) a report of neglect after investigation was deemed to be low to moderate risk

as determined by DPSS's Family Needs Assessment; 2) have a child (ren) between the ages of 0-18; and 3) client admits to having substance abuse problem. The Riverside's Department of Public Social Services and Drug Endangered Children Program will play a lead role in identifying and referring clients who meet the eligibility requirements during an investigation of reported child abuse or neglect. The clients will be referred to a process known as DPSS's "Differential Response", whereby an assessment is conducted to determine the level of the drug-dependency problem and the children's safety. Upon completion of the DPSS's Family Needs Assessment, the Structural Decision Making Team reviews the assessments and identifies those clients who have a low and moderate safety risk for child abuse reporting. In addition to the DPSS assessment, clients will be asked a series of questions pertaining addressing the problems of substance abuse. These clients identified through DPSS assessment will be asked to volunteer in the FPC services for 12 months and receive additional 12 months.

The targeted population and geographic areas are characterized by high rates of substance abuse, crime, poverty, isolation, gang activity, drug-related problems, a large number of Children Protective Service referrals, and high incidents of methamphetamine labs and distribution. These geographic areas, and problems have been identified by three County needs assessments: (1) DPSS Supplemental Implementation Plan (SIP); (2) United Way of the Inland Valley's Community Profile and (3) Riverside Superior Strategic Plan. These County needs assessments will be used to help identify and address the needs and gaps in services to resolve our growing drug dependent and foster care placement problems. The following are the FPC geographic areas being targeted:

East Indio. Located in the east desert, East Indio is a rural area with its primary economy relying on agriculture. It is comprised of a large geographic area including the diverse communities of Indio, Coachella, Indian Wells, and Blythe. Of the total residents in Riverside County in 2000, 7.4% reside in this eastern desert area. Unlike the rest of the county, the majority of residents are Hispanic (78%) and few are White (18%). Asian/Pacific Islanders, American Indians, African American, and other races make up to 4% of the population. Ten percent of the residents in this first region participate in Medi-Cal compared to 13% countywide (U.S Bureau Census 2000).

Southwest Area: The Southwest County encompasses many cities experiencing sudden growth in population due to its affordable housing including Temecula, Murrieta, Hemet, San Jacinto, Winchester, Anza, Idyllwid, Mountain Center and Aguanga. Of the total population in Riverside County, 21.4% of people live in the Southwest area. The ethnic composition in the Southwest area is 71% White, 21% Hispanic, 2% African American, 2% Asian/Pacific Islanders, 2% other/multi race, and less than 1% are American Indian. The Hemet/San Jacinto area has the largest pocket of Hispanics (23%) living in the Southwest Area. This creates an additional challenge since the Hispanic population faces added hardships in receiving services due to language and cultural barriers. Nine percent of its residents participate in Medi-Cal (U.S Bureau Census 2000).

Riverside Metro Area The City of Riverside is the largest city in the county home to over 18% of people in Riverside County, 46% of whom are White, 37% Hispanic, 7% African American, 6% Asian/Pacific Islanders, 3% other/multi race, and 1% American Indian, which is closely representative of the population in Riverside County. Thirteen percent of residents in this region participate in the Medi-Cal program (U.S Bureau Census 2000).

2. Nature of the Problem and Extent of Need

Characteristics of Riverside County

Riverside County is the fourth largest county in California neighboring Los Angeles, Imperial, Orange, San Diego, and San Bernardino Counties. With 32% population growth between 1990 and 2000 (U.S. Bureau of Census, 2000), Riverside County is one of the fastest growing counties in California with a current population of 1,545,387. The ethnic composition of the County is 51% White, 36% Hispanic, 6% African American, 4% Asian/Pacific Islanders, 2% other/multi race, and 1% American Indian. With the increases in population, Riverside County has also experienced high rates of poverty, crime, child abuse/neglect, and violence. Although the percentage of persons living below the poverty line was the same for both Riverside County and the State at 14.2%, the per capita income in 1991 was approximately 18% lower for Riverside County ($18,689) compared to the State ($22,771), (U.S. Bureau of Labor Statistics, 1991).

Alcohol and Drug Arrests

One of the most notable challenges facing the county is substance abuse, especially of alcohol and methamphetamines. The total arrest rates for Riverside County in 2000 was slightly lower than the State (3.5% vs. 4.2%) and Nation (4.9%). However, the percentages of people arrested for alcohol related infractions (e.g., driving under influence, liquor law violations, and drunkenness) were higher for Riverside County (28.2%) than State (22.8%) and National (19.97%),
(California Bureau of Criminal Information and Analysis, 2000). Based on the drug arrests data from the Criminal Justice Statistics Center (2000), there were 9854 drug arrests in Riverside County, of which 53.3% were felony drug offenses (e.g., manufacture, sale, possession in large quantity of dangerous drugs, marijuana, narcotics, and other drugs), and 47.7% were misdemeanor offenses (e.g., simple possession of marijuana and other drugs). Of the total drug arrests, 8.4% were juvenile arrests. More arrests were reported for juvenile offenders in Riverside County for misdemeanor (74.4%) compared to the State (71.9%).

In 2003, 101 reported methamphetamine labs were seized in Riverside County, which increased the total number of labs seized to 1,229 since 1998 (Inland Narcotic Clearing House, 2004). In a 2003 report 75 children were found in these seized labs, the highest number of children exposed in the State (in comparison 18 children exposed in Los Angeles County and 23 in San Bernardino County). In addition to problems of methamphetamine labs in Riverside County, drug trafficking organizations based in Mexico transport cocaine, methamphetamine, marijuana, and heroin through the Inland Empire making drugs easily available for people in Riverside County (California Department of Justice, October 19, 2004). Riverside County is attempting to combat this problem by participating in the Inland Crackdown Allied Task Force to assist local, State, and Federal agencies target Mexican and Columbian cartels.

Riverside County Admission for Alcohol and Drugs

According to the California Alcohol and Drug data system, a total of 9765 clients (60% male) were admitted to Substance Abuse Programs in Riverside County from July 1, 2002 to June 30, 2003. Of this total, 85% of clients were between ages 21 and 50 years old, while only 9% were ages between 18 and 20 years old. Most of these clients were White (51%) and Hispanic (36%), followed by African American (8%), American Indian (2%), and Asian/Pacific Islanders (1%).

As evidence of the methamphetamine problems facing Riverside County, 53% of clients were admitted with their primary drug use issue as methamphetamines followed by Heroin and Alcohol both at 15%. Ten percent of clients were admitted with their primary drug use issue as marijuana. Over half of clients reported using their primary drug before 17 years old (27% reported using before 15 years old and 28% reported using between 15 and 17 years old). Thirty percent reported using their primary drug between 18 and 25 years old, while 16% reported using after 26 years old.

Riverside County Child Protective Services

Riverside County Children's Service Division is composed of approximately 810 employees with over 400 social workers. In 2004, the Children's Service Division received over 56,104 reports of suspected child abuse/neglect and with over 42% (23,906) of those calls resulting in a referral. From those referrals, 4,741 were substantiated with evidence of child abuse/neglect (Department of Public Social Services, Children's Service Division). Additionally, as of January 2005, there were a total of 6,975 open dependency cases with approximately 4,100 children having received out-of-home placements. It is estimated that in Riverside County, approximately 70% to 80% of children currently entering the foster care system do so as a direct result of parental substance abuse issues. The majority of children involved in these opened dependency cases are Hispanic (43%) and White (36%). Children between the ages 0 and 17 in Riverside County entered the Foster Care System for the first time at a 1.5 times higher rate (.45%) than the State's rate (.28%). Additionally, higher percentages of children in the Riverside County Foster Care system were being neglected and abused (1.05%) compared to the State percentage (.85%) in 2003. The recurrence rate of abuse and/or neglect for who children were not originally removed was higher for Riverside County children (9.5%) compared to the State's (8.8%) recurrence rate (Needell, Webster, Cuccaro-Alamin, Armijo, Lee, Lery, Shaw, Dawson, Piccus, Magruder, Kim, Conley, Henry, Korinek, Paredes, & Smith, 2005).

3. Riverside County Priorities

This proposed project integrates the three strategic plans that reflect the Riverside County priority needs relating to substance abuse and mental health. These include; better quality substance abuse and mental health services, coordination and collaboration of social support services for families faced with substance abuse problems, court collaboration and flexibility of policies to ensure completion of cases for drug dependent parents. Additional priorities are reported in the Department of Public Social Services Supplemental Implementation Plan (SIP), United Way of the Inland Valleys Community Profile Health and Human Service Needs, and Riverside Superior Court Strategic Plan, which can be found in Appendix 5.

Section B: Proposed Evidence-Based Service/Practices (30 points)

Purpose, Goals and Objectives of your Proposed Project

The overall goal of this proposal is to ensure that treatment clients have immediate access to quality and culturally appropriate services necessary to build stronger family units, keep families together, and provide parents with the necessary tools to increase self-confidence and live a sober healthy life style. Table 1 illustrates the proposed objectives, effective programs and best practices, and measurable outcomes. Four objectives to be measured, include:

Objective 1: *To strengthen Riverside agency systems efforts in collaboration and coordination by expanding the treatment services program for Riverside FPC participants referred by DPSS's Central Unit/Differential Response .*

Objective 2. *To expand and enhance the capacity of the FPC to provide drug treatment services to increase family functioning skills by 10% by the end of the project.*

Objective 3. *To strengthen social support services by addressing the needs and problems facing drug-dependent parents and their children in their community.*

Objective 4: *To conduct a process and outcome evaluation to inform local and State governance about the efficacy and cost savings associated with the FPC and to improve family drug court operations.*

The overall program goals and objectives of FPC will document and evaluate innovate practices that address critical substance abuse and mental health service gaps that have not been formally evaluated. The project proposes to address the gaps in substance abuse and mental health services in three geographic areas reported as having serious, emerging mental health and substance abuse problems. We propose to assess the impact of family treatment drug court interventions. We will examine retention rates in substance abuse treatment and outcome so that an improved treatment service delivery system for retaining and treating persons with substance abuse disorders can be developed, described, and evaluated.

Logic Model and Measurable Goals, Objectives and Outcomes

Table 1 is the Logic Model for FPC, and demonstrates the Strategies/ Interventions, Research Questions, FPC Elements and Outcomes. The goals, objectives, and outcomes for the project are specified and measurable. Each intervention is based on effective practices known to contribute to effective programs. As described in the Evidence-Based Intervention Table 2, the activities in each intervention are designed to increase parent and family functioning. Table 1 in this section describes the goals, measurable objectives, strategies/activities, research questions, RFA requirement elements, and proposed outcomes. *Appendix 2* contains the workplans for the process and outcome evaluations that clearly demonstrate the detail with which we intend to measure each objective.

Table 1. *Summary of the Goals, Objectives, Intervention, Program Characteristics or Activities and Theoretical Framework*

Program Goal: To ensure immediate access to quality and culturally appropriate services necessary to build stronger family units, keep families together and/or provide parents necessary tools to increase self-confidence and live a sober healthy life style.			
Objective 1. To strengthen agency systems efforts in collaboration and coordination by expanding the treatment services program for Riverside FPC participants referred by DPSS's Central Unit/Differential Response			
Strategies/Interventions/Practices	Research Questions	Family Treatment Drug Court Elements	Proposed Outcomes/ Outputs
• Convene a multi-agency, multi-site steering committee to guide practices and procedures to ensure safety for children. • Establish early identification response with DPSS Differential Response. • Alternative Family Resolution (AFR) support services to protect participant's due process rights. • Case management cross collaboration and communication support. • Training provided to team to promote effective planning, operation and implementation.	• How closely is the structure and implementation of FPC program matching the proposed plan? • What are the obstacles, barriers, and solutions to the implementation and effectiveness of the program?	• Steering Committee composed of key stakeholders • Protecting participant's due process rights. • Early Identification and prompt placement. • Interdisciplinary education that promotes effective planning, implementation and operations. • Practices and procedures to ensure that the safety and welfare of the abuse and neglected child is placed above the needs of the adult. • Appropriate confidentiality requirements that are specific to individuals under court supervision	Adoption of 11 key elements and 5 Family Drug Court elements Procedures Manual Increased collaboration Increased trainings Establishment of confidentiality procedures Use of best practices

Table 1. *Summary of the Goals, Objectives, Intervention, Program Characteristics or Activities and Theoretical Framework (cont.)*

Objective 2. To expand and enhance the capacity of the FPC to provide drug treatment services to increase family functioning skills by 20% by the end of the program year..			
Strategies/Interventions	Research Questions	Family Treatment Drug Court Elements	Proposed Outcomes/ Outputs
• 12-month Substance Abuse Treatment services. • Aftercare support and services. • Nurturing Families Program • Life Skills Workshops • Child development and school readiness Workshops • Education and employment services to improve parent's ability to care for their children. • Case management services • Social support service. • Follow-up services	• What programs and procedures were modified to improve the effectiveness of the program? • What individual factors are attributable to the clients' success or failure in the program?	Access to continuum of alcohol, drug, and other related treatment. Alcohol and other drug treatment services that are integrated with justice system case processing. Frequent Alcohol and other drug testing. Coordination strategy that governs drug court responses to participants' compliance.	Reduce time in foster care Timely establishment of permanency Maintain primary connections to siblings and extended families and community Percentage of positive use during program measured by four phases.

Table 1. *Summary of the Goals, Objectives, Intervention, Program Characteristics or Activities and Theoretical Framework (cont.)*

Objective 3. To strengthen social support services by addressing the needs and problems facing drug-dependent parents and their children in their community.			
Strategies/Interventions	Research Questions	Family Treatment Drug Court Elements	Proposed Outcomes/ Outputs
• Convene community outreach support services • Judicial supervision during hearings. • Social worker support in ensuring placement for children.	• What program factors are critical components of clients' performance?	• Partnership among drug courts, public agencies and community-based organizations. • Judicial interaction that is ongoing with each drug court participant. • Appropriate timely placements for children consistent with the requirements of the Adoption Safety Family Act	
Objective 4. To conduct a process and outcome evaluation to inform local and state governance about the efficacy and cost savings associated with the Family Preservation Court program and to improve family drug court operations			
Strategies/Interventions	Research Questions	Family Treatment Drug Court Elements	Proposed Outcomes/ Outputs
• Administer appropriate process and outcome instruments • Provide feedback on program and intended outcomes • Evaluate the compliance of 11 key elements. • GPRA requirement and assurances.	• What are the benefits for clients as a result of participating in FPC program?		• Reduce the frequency & duration of out-of-home placements. • Increase retention in drug treatments • Reduce reports of child abuse/ neglect& referrals to MHS. • Reduce parental drug use, criminal activity, parental stress, and depression, & improve parental functioning.

2. Identification of Evidence-Based Services/Practices and Justification

Table 2 describes the evidenced-based services, practices and justification for implementation as proposed for FPC.

Table 2. *Evidence-Based Services/Practices and Justification*

Evidence-based services proposed to Implement
Mental Health: We propose to provide substance abuse and mental health services that are principle based and effective. Such services include the use of assessment, strategies, settings and models for treating patients. Outcomes for patients are enhanced when both illnesses are addressed using an integrated approach.. Upon training Family Preservation Court treatment counselors will be in a position to recognize and refer clients for therapy when demonstrating signs of dual diagnosis. **Best Practices (Tips & Taps):** Treatment Improvement Protocol (TIP 42) from U. S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. Center for Mental Health Services Evidence-Based Practice Toolkit.
Substance Abuse: We propose a comprehensive program in which services are designed to achieve progressive changes in an individual's thinking and alcohol/drug using behavior in order to prevent relapse. We also propose a program where the family is engaged in a healing process through the focus on recovery to the entire system that has been compromised by substance abuse. To accomplish this, services address major lifestyle, family attitudinal, and behavior issues, which can undermine the goals of treatment or inhibit the individual's ability to cope with major life tasks without the non-medical use of psychoactive substances. **Best Practice (Tips & Taps):** Treatment Improvement Protocol (TIP 35) from U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment: "Enhancing Motivation for Change in Substance Abuse Treatment". Motivational Interviewing methods will be used, and additionally, the "Stages of Change" Model of recovery will be introduced to clients in the psycho-educational component of our curriculum. All counseling staff will be oriented to Motivational Interviewing methods and will utilize the appropriate motivational strategies for clients at each corresponding stage of change. Some gender specific classes will be offered to parents attending the program. Stephanie Covington: "Helping Women Recover" is a comprehensive strengths based program for substance abusing women. The program modules are "Self, Relationships, Sexuality, and Spirituality." Covington, S. S. (1999). Helping Women Recover. San Francisco: Jossey-Bass Inc. Curriculum materials on Relapse and Relapse Prevention are based upon research by Terence Gorski, and his "Staying Sober" workbook and handbook. Gorski, T., & Miller, M. (1986). Staying Sober. Independence, Missouri: Herald House/Independence Press. Other curriculum materials include presentation of the following topics: Five Stages of Change, Addiction: The Disease, Physiological Effects of Addiction, Psychological Effects of Drugs, Social Effects of Drugs, Pharmacological Effects of Drugs, Self Esteem, Communication, The Family (Part I) and The Family (Part II), Codependency, Family Violence, Feelings (Shame and Guilt and Grief and Loss), Relapse/Recovery (Part I and Part II), Recovery Planning, and Goals.

Table 2. *Evidence-Based Services/Practices and Justification (cont.)*

Child Development Workshops: Parenting Education Workshops will meet Welfare and Institutions Code 16507.7 requirements, and include topics such as "Building Self Esteem", "Handling Stress and Anger – (for parents and children)", "Growth and Development of Children – (including attachment and bonding and temperamental characteristics of children)", "Developing and Increasing Communication Skills", Learning to Use Positive Disciplinary Mechanisms", and "Learning the Boundaries of Permissible Sexual Conduct".

Additionally, we will include topics such as "Selecting Safe and Appropriate Childcare", "Meeting a Child's Basic Physical and Emotional Needs", "Alternative Discipline Methods (Parenting styles and techniques)", "Appropriate Child Development", "Parent/caregivers' Role in Preparing Their Children for School Readiness", and "Nutrition (including dangers of child obesity)."

Best Practices(NREPP): Blueprints Model Programs Incredible Years Series: Incredible Years Training for Parents. The Incredible Years Series is curriculum designed to promote emotional and social competence and to prevent, reduce, and treat behavior and emotional problems in young children. The parenting series includes three programs targeting parents of high-risk children. The BASIC program will be used in Phase I and II of the Child Development Workshops, and the ADVANCED program will be used in Phase III and IV. The SUPPORTING YOUR CHILD'S EDUCATION (SCHOOL) Program will be implemented in the School Readiness portion of Phases I through IV.

Family Prevention/Intervention Services: We believe that a family centered parenting program is a key intervention for families whose lives have been disrupted by substance abuse and related dysfunction within the system. Many of the families have experienced separations, multiple foster care placements of the children, and children have been exposed to various levels of physical, sexual and emotional abuse or neglect due to substance abuse in the home. Combined parenting education and parent/child activities provide for concrete demonstration of positive experiences that work to build strong character in children.

Best Practices(**NREPP):** SAMHSA Listed as Model "Nurturing Parenting Program" for: 1) Parents and Their Infants, Toddlers, and Preschoolers, 2) Parents and School Age Children Program (5-11 years), and 3) Parents and Adolescents Program. This program was developed based upon a 2 year research project by the National Institute of Mental Health (see attached information on curriculum). This curriculum will be used throughout the phases, and activities for parents and children will be planned according to visitation schedules by DPSS.

Initially, for each child, a baseline of "bondedness" to parents will be established, and need for referrals for therapy or psychiatric assessment will be made. Additionally, referrals may be made to Public Health Nursing for developmental testing of children under 5 years of age.

Case management: In our experience with implementing family drug courts, it is critical and important to have case management services at a court level to help reduce the disparities of our services and help to increase systems communication to provide clients with adequate, culturally appropriate services. The bilingual/bicultural case managers will focus on a family-centered, strengths based needs-driven planning process and create culturally and linguistically individualized services and supports for children, youth and their families. The case managers will serve as a broker of services for clients and resolve barriers and disparities of services across the systems.

Best practice (TIPs & TAPs): Comprehensive Case Management for Substance Abuse Treatment (TIPS 27) (1998) NCADI#BKD251 and Navigating the Pathways: Promising Practices in Linking Alcohol and Drug Services with Child Welfare (TAP) Series 27 (2002).

3. Ensuring Effective Adaptations For The Target Population

Our collaborative work will encourage fidelity of the proposed evidence-based services/practices to be implemented. However, we do recognize the need to adapt and modify the original model for the purpose of allowing the implementers to be resourceful; to adjust for specific needs of the client population; and to address unique characteristics of the local community where the service/practice will be implemented. Such efforts will be documented to examine the cultural impact these activities have on the clients. The treatment providers proposed in this project will follow the practices of the National Standards for Culturally and Linguistically Appropriate Services in health care (DHSS, 2001). Some of these standards include, but are not limited to:

- Ensure that patients/consumers receive effective, understandable and respectful care compatible with their cultural health beliefs and practices.
- Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- Implement strategies to recruit retain, and promote at all levels of the organization and that is representative of the characteristics of the population.
- Offer and provide language assistance services, including bilingual staff and interpreter services at no cost during all hours of operation.
- Provide verbal offers and written notices information them of their right to receive language assistance services.
- Assure the competence of language assistance provided to limited English proficient patients.
- Maintain a current demographic, cultural and epidemiological profile of the community as well as the need to accurately plan for implementation of services.

4. Addressing Target Population Issues

In order to address issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender in target population while maintaining fidelity, we have identified the following strategies in resolving disparities with our targeted population:

- Hiring bilingual and bicultural staff and paraprofessionals from the racial/ethnic group in service area.
- Providing continued education workshops on issues related to serving diverse populations and culturally responsive treatment techniques.
- Establishing natural helping networks and support systems in the community, which makes services more accessible to racial/ethnic cultural groups.
- Developing strategies to serve across diverse population and geographic areas
- Equalize access to services and to produce comparable outcomes of care across ethnic groups.
- Identifying and eliminating barriers to access based on ethnicity, culture, socioeconomic classes, gender and sexual orientation to newly initiated or mandated programs.
- Increasing access to culturally competent services that are sensitive to youth and family strengths and needs.

- Co-locating mental health services near courthouses to improve access in remote or rural communities.
- Encourage and develop strategies to include and engage racially and ethnically diverse families in prevention, intervention strategies.
- Communicating effectively with diverse populations and providing educational programs, materials, and informational resources that reflect understanding of culture, ethnicity, age, and gender.

5. Meeting the Goals and Objectives

The FPC Logic Model proposed demonstrates how the proposed service/practice will meet your goals and objectives, that link needs, the services or practices to be implemented and can be found in Table 1, Section B of the proposal.

Section C: Proposed Implementation Approach

1. Implementation of Proposed Services and Practices

The Riverside FPC proposes to expand and enhance services to a new-targeted population within the court system known as "Pre-filing". Parents who have an underlying concern with substance abuse who do not have an open petition will be referred to FPC services. This is an innovative, comprehensive, and family-centered approach to keep families together prior to filing a petition. This proposed service addresses the needs of Department of Public Social Services as described in Supplemental Implementation Plan. Utilizing an Alternative Family Resolution (AFR) similar to Family Law's Alternative Dispute Resolution process whereby a mediator reviews all parental rights and directive plan of action. AFR is facilitated by social worker offering, a "Family-2-Family" format that ties extended family members and community to support the recovering family.

Our proposal will be implemented in an AFR process initiated prior to the filing of a petition in the juvenile court. This will enable participating families to obtain intensified recovery services provided by the drug court prior to action being taken to remove their children from their home. DPSS will facilitate the intensive 12 month program. This program will enhance the traditional Family Maintenance Voluntary (FMV) program by providing a structured, goals oriented, and intensive recovery program supervised by a professional interdisciplinary team utilizing the existing dependency drug court program.

Riverside's Department of Public Social Services and Drug Endangered Children program will play a lead role in identifying and referring clients that meet the eligibility requirements during an investigation of reported child abuse or neglect in the East Indio, Riverside Metro, and Southwest areas. Clients will be referred to a process known as "Differential Response" whereby an assessment is administered to examine the level of drug-dependency problem and children's safety. Clients that rate low to moderate risk and safety, and admit to having a substance abuse problem will be asked to volunteer in the FPC intensive treatment services for 12 months. Clients completing the 12 month program will receive aftercare services for another 12 months provided by Mental Health Systems.

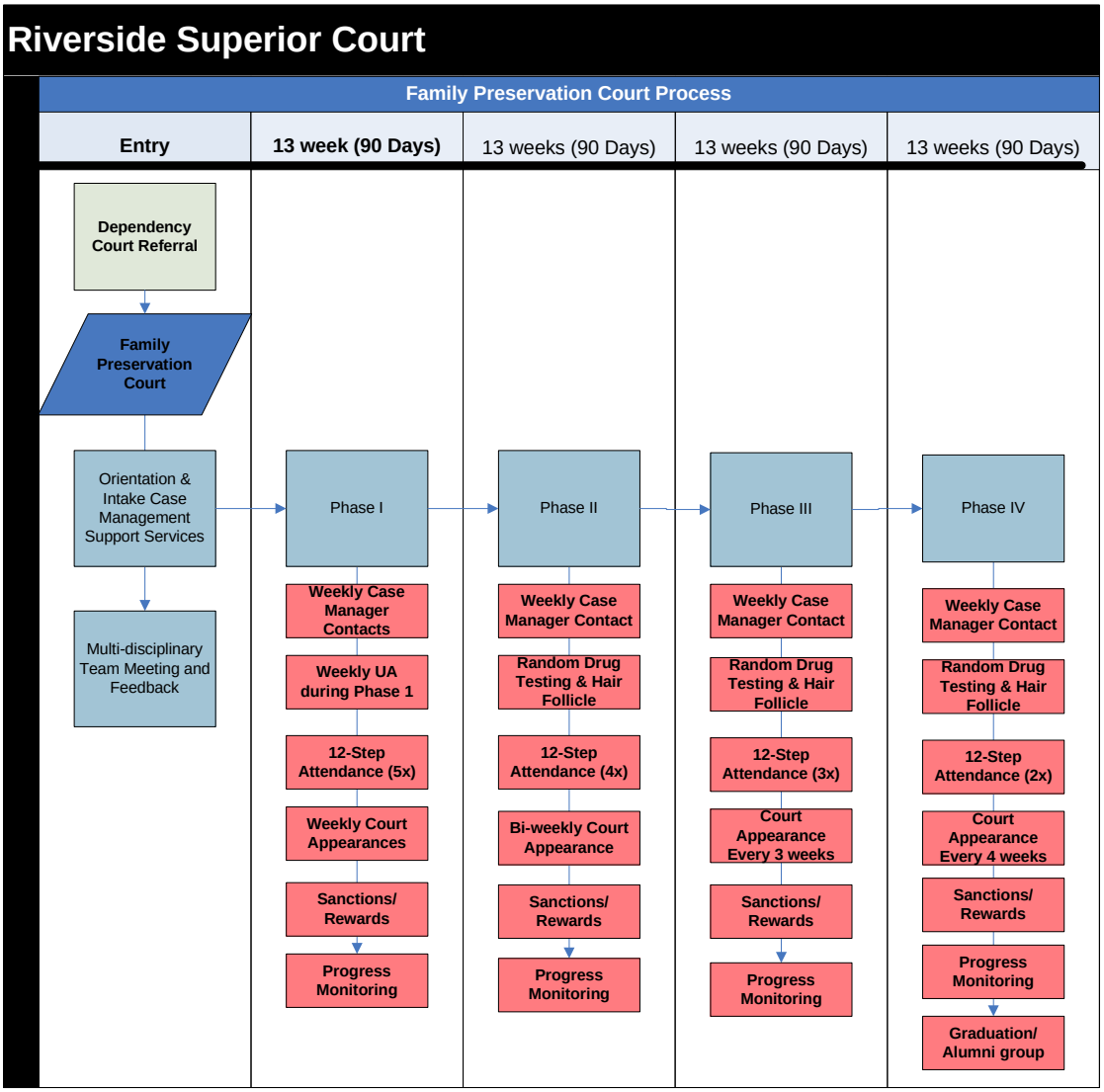
Immediately following the court intake, the client is given a referral for a substance abuse assessment to Mental Health Systems and/or the local County Substance Abuse Program. The case manager introduces the client's profile to the multidisciplinary team to review and approve participation. Client's participation will be reported to DPSS. Family Preservation Court is a

four-phase program including required random (4 times per month) testing in the first two phases and 2 times per month in Phases III and IV. Prior to a phase promotion or graduation, each client must pass a hair follicle drug test and write an essay as to why they are deserving of promotion. Random drug testing will be supervised by MHS.

The FPC case manager receives a referral and reviews the documents from the AFR mediator within 72 hours of completing the family conferencing documents. The client completes a Family Needs Assessment and Personal/Growth Skills Checklist. Case managers explain the program in more detail going over the instructions of the phase compliance checklist and parents sign the acknowledgment that they have read and understand the process and services. Phase requirements are abbreviated as the client reaches the higher phases. At the hearings the judge/commissioner assigned reviews case and information with client, and formally enrolls the client into FPC.

Figure 1 illustrates the Court Standard of Operation for FPC Process. There are four proposed 90-day phases to be facilitated and supervised by a multidisciplinary team for 12 months. Process begins at identification of an eligible client from DPSS Central Unit

Figure 1. *Family Preservation Court Process*



Project Treatment Services and Activities

There is an overlay of services that are applied to the four-phase Family Preservation Process, they include Parent and Family Treatment Services Table 3, describes all of the services that will be provided to the parents, children and the family. There will be case manager co-located in each court, supervised by MHS. In collaboration with Mental Health System, we propose to provide intensive outpatient treatment services to pregnant, postpartum and parenting women, fathers and their minor children, providing services to the entire family, thus increasing positive treatment outcomes for individual women and their entire family. in a linguistically and culturally appropriate manner Mental Health Systems proposes to conduct and implement the following treatment services illustrated in Table 3, for parents, children and overall family.

Table 3. *Treatment Services for Parents and Children in Recovery*

Parent Treatment Services	***Children and Recovery Support Services***	
	Children	***Family***
• Outreach, Screening, Assessment and Intake, and case management. • Detoxification/Residential Referral • Individualized Service Plan, updated every 90 days (or as needed) • Substance Abuse Education and Treatment Workshops, Group Counseling Sessions, Individual and Family Counseling, and Recovery Services: daily education, counseling and recovery services. • Medical, Dental, and Other Physical Health Care Service Referrals • Child Development Training: twice per week • Education, Screening, Counseling, Treatment of Communicable Diseases, to include HIV prevention, education and training: in-group counseling and as needed. • Mental Health Assessment and Treatment Referrals. • Employment Readiness, Training, and Placement. • Education and Tutoring for GED and Higher Education Attainment. • 12-month Aftercare	• Screenings and Developmental Diagnostic Assessments for Children Referral • Therapeutic Intervention Referrals • Pediatric Health Care Referrals • Social Services and Financial Supports Referrals • Education and Recreational Referrals • Counseling services • School Readiness	• Individual and Family Counseling/ Therapy. • Alcohol and Drug Education on Family in Recovery • Parenting Training: twice per week • Referral Services • Family Nurturing interventions • Natural support groups • Recovery Planning Groups

Community Outreach Support

In addition, the court will assemble and deploy a Community Outreach Team to speak with the local communities to educate and recruit support to ensure long-term recovery for these families. These teams will include judicial officers, recovery experts, social workers, legislators from all levels of government, and even family members. California law mandates and encourages the use of community resources in the areas of child protection and preservation of families (See Appendix 5

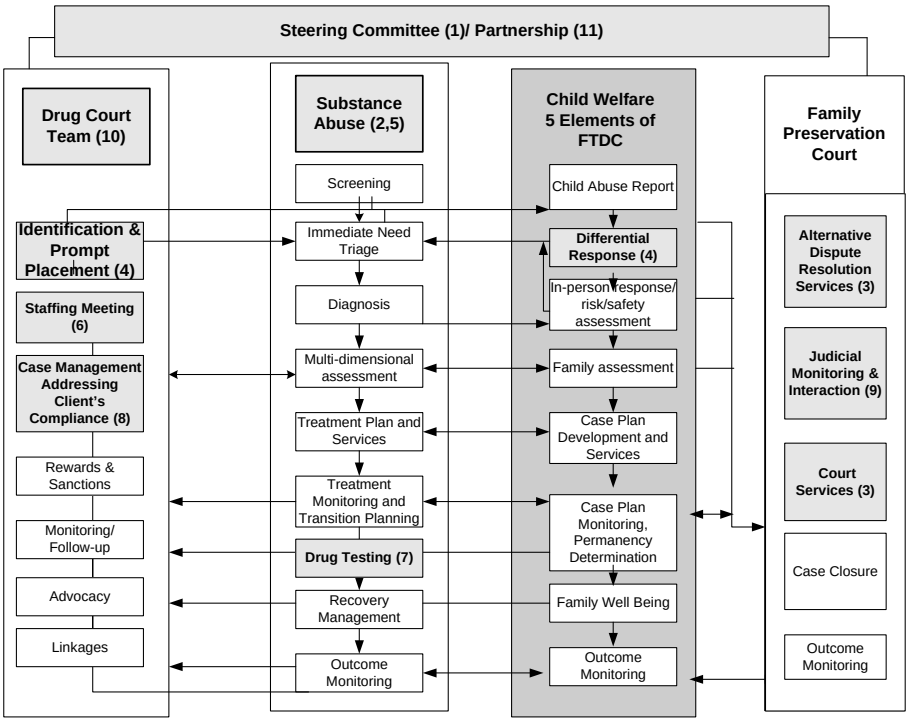
for Riverside Superior Strategic Plan). The Standards of Judicial Administration (2001) recommended by the Judicial Council identify the unique role of a juvenile court judge to provide active leadership within the community in determining the need of obtaining and developing resources and services for at-risk children and families. This team will invite other community groups like People Helping People, Circle of Care, St Martha's, and Desert Alliance for Community Empowerment who offer food, clothing, housing referrals, life management training, and hope for renewed life.

Integrating the 11 Required Key Elements and the 5 Elements for Program Design

Figure 2 illustrates the operational plan and path of communication across the service systems. This diagram was developed based on research recommended in understanding and detailing the path of communication. The case manager will be involved in the communication process across the systems (i.e., Child Welfare, Substance Abuse Program, courts). The case manager in this pathway model works towards building a relationship with partnering agencies' staff that focuses on understanding agency policies and ethics of service delivery. Communication and buy-in will be crucial to gathering all of the necessary information to help clients reach their goals. The case managers will also bring together the coordinated systems service plans that focus on recovery as a priority leading to family preservation. This type of case management weaves a level of case management services into strengthening the systems of communication for the court in order for it to make better decisions for improving inequities among clients living in the targeted geographic areas. In addition, we have successfully weaved the elements into this process, which guides the operation of the project. The following is a description of how this project proposes to adopt and integrate the elements as illustrated in Figure 2**.**

Figure 2. Integration of 11 Key Elements and 5 Program Design Elements

Family Preservation Court
Operational Plan and Pathways of Communication



*Shaded areas represent 11 Key Elements of Drug Court and 5 Family Treatment Drug Court Program Design Elements

(1) A Steering Committee: Key stakeholders will advise in the design and operation of the FPC. The Committee is composed of members representing the County of Riverside Department of Mental Health, Mental Health Systems, Inc., County of Riverside DPSS Drug Endangered Children's Program, WestEd, People Helping People, Circle of Care, and Inter-Agency Counsel.

(2) Alcohol and other drug treatment services: We are strongly convinced that the Drug Court Program effectiveness is a direct result of combined treatment. Treatment providers will provide immediate access to specific individual and family orientated services.

(3) Use of non-adversarial approach: The Family Preservation Court Team brings together the perspectives of both the prosecution and defense counsels, and further includes law enforcement, the judge, and the treatment provider to resolve barriers to services for drug dependent parents. The families coming through our program will not have a case filed, however they will sign a contract with the program agreeing to terms and conditions. Both prosecution and defense counsel will be involved to promote public safety while protecting participants due process rights.

(4) Early identification and prompt placement: The very nature of the court is to identify families in crisis at the earliest stages and give them immediate access to intensive services and supervision. This will be achieved by developing appropriate screening criteria (a team joint venture of preparing for the FPC).

(5) Access to alcohol, drug, and other treatment: Once participants are admitted to the FPC,MHS and County of Substance Abuse Program are committed to ensuring that participants have access to a continuum of alcohol, drug, and other related treatment and rehabilitation services. MHS has established excellent working relationships with residential treatment providers and other service agencies in the Riverside County area. MHS will expedite services and provide immediate service within 24 to 48 hours upon client agreement to participate.

(6) Frequent staffing (team meetings):Weekly staff meetings will be held where cases will be presented and client progress, strengths and challenges will be reviewed. At this time, treatment plans may be modified and goals reassessed, and need for referrals may be identified. Frequent impromptu treatment team meetings may be held for clients experiencing crisis situations or for treatment issues that need to be discussed.

(6) Frequent drug testing: Drug testing will be done on a frequent and random schedule utilizing urine testing and hair follicle during phase promotion and/or as requested to determine relapse.

(7) A coordinated compliance strategy: The FPC will utilize existing protocols for graduated sanctions and rewards in an effort to monitor participants' compliance. There will be weekly staff meetings held prior to each hearing to monitor and ensure compliance.

(8) Judicial interaction. Compliance is stressed by the treatment provider and is reinforced through each participant's ongoing judicial interaction at the court hearings. Participants will report to the judge every week for the first phase, every two weeks for the second phase, every three weeks for third phase, and every 4 weeks for the fourth phase. Compliance and goal achievement by individual participants are assessed objective by use of the quantitative measures described below.

(9) Interdisciplinary education. All of the key components rely on the efficacy of the FPC Team. There is a team conference prior to Court every week. This provides a natural opportunity for the continuing interdisciplinary education necessary to make the FPC operate more effectively. MHS, local, regional, and national training conferences provide more explicit opportunities to share disciplinary perspectives with others who are committed to the long-term project goals.

(10) Partnership: Partnerships have been developed with public agencies and non-profit and community-based organizations. Each member of the Team comes to understand, accept, and appreciate the perspectives of the other Team members. Our Community Outreach Team is currently making presentations on a regular basis to educate the community about the dependency system, problems, solutions, and how to get involved in the community at large.

2. Implementation Timeline, Activities, Milestones, and Responsible Staff

Table 4, provides a description of project implementation timeline. The timeline illustrates planning and implementation activities.

Table 4. *Timeline*

Anticipated Date	Week	Activity	Completion Date	Person Responsible
October 2005	1	Notice of Intent to Award	N/A	Project Director
	2	Meet with Key Partners and Finalize MOA/MOU to be given to SAMHSA following day.	10/7/05	Project Director/ Key Partners
	3	Coordinate and Meet with Family Preservation Team incorporating all sites.	10/21/05	Project Director
	4	Meet with treatment providers and finalize any changes, barriers and challenges.	10/21/05	MHS HR Dept.
		Ensure that all subcontractors understand the need to establish a cultural and linguistic plan to address needs of the target population (i.e. hire staff, training, planning new strategies).	10/28/05	MHS AOD Division & HR Dept

Table 4. *Timeline (cont.)*

November 2005	1	Conduct First Interviews Conduct Second Interviews Make employment offers Complete hire/transfer process.	11/11/05	MHS HR Depart
	2	Complete Employee Screening (UA, TB Tests, Fingerprints, and Background Checks) and Obtain Results.	11/30/05	MHS HR Dept.
	3	Create training schedule on the Project goals and objectives, plan for implementation to all court staff, MHS, and WestEd. Begin the process of carrying out training.	12/9/05	Project Director/ WestEd's TA
	4	Purchase any necessary supplies, curriculums, and materials that support the implementation of the interventions.	12/9/05	MHS Facilities Dept. Program Manager
	5	Begin organizing, developing, setting protocols for new forms/reports.	1/18/06	Project Director, MHS AOD Division & WestEd TA & Evaluation
December 2005	1	Finalize all implementation of services and case management protocols.	1/18/06	Project Director, MHS AOD Division & WestEd TA
	2	Meet with Evaluation and finalize GPRA and all data collection methods, identification of data sources and coordination with key partners MIS.	1/9/06	Project Director, MHS AOD Division Loryx & WestEd Evaluation
	3	Obtain all necessary Loryx-Transition computer licenses and finalize the installation of software.	12/16/05	Project Director, Loryx & WestEd Evaluation
	4	Train all staff involved in the project on the Loryx database system.	12/30/05	Loryx and WestEd Evaluation
	5	Train all judicial and court staff involved on the implementation of the project, their roles, and responsibilities.	1/9/06	Program Manager, MHS FS Division, County MH
January 2006	1	Begin the process of referral from each site.	1/27/06	Indio, Southwest, Riverside Team Members
	2	Program Fully Operational and ensure all interventions are ready to start.	1/31/06	Project Director, MHS, and County
	3	Continue Training/Orienting Staff and Holding Staff Meetings Every Week.	Ongoing	Project Director and Team Members
	4	Hold Open House for team members and existing clients and families to Discuss New Consolidated Program Establish linkages with resource agencies.	Ongoing	Project Director and MHS AOD Division
February 2006	1	Start-up of Services and Interventions.	Ongoing	Project Director, Court Teams, MHS, County and WestEd

3. Number Proposed To Serve and Type of Services

FPC proposes to provide clients enrolled in the program with AFR services, case management, alcohol, drug, mental health treatment services, child development workshops, and life skills. Children and families will be provided with family intervention program, recovery support,

school readiness and family counseling/therapy. A detailed list of services is provided in Section B of this proposal. Parents will be administered the GPRA survey at the time of enrollment. Children and Family will not be required to complete any surveys, except for satisfaction evaluation of services provided. Table 5 details the number of clients to be served and families that will be impacted.

Table 5. *Number of Services*

	Year 1			Year 2			Year 3		
Target Population	**Indio**	**Riv**	**SW**	**Indio**	**Riv**	**SW**	**Indio**	**Riv**	**SW**
Parents	40	40	40	40	40	40	40	40	40
Total Anticipated to Service	120			120			120		
Children & Family (average 3.5)	140	140	140	140	140	140	140	140	140
Year Total	540			540			540		

Identification, Recruitment and Retention of Target Population

The process begins at identification of an eligible client from DPSS Central Unit / "Differential Response" The client completes a Family Needs Assessment and Personal/Growth Skills Checklist. Retention begins at this point, whereby the case manager guides clients through the FPC and immediately connects them with MHS so they can receive treatment services right away. Rewards and sanctions will be identified that are specific to their needs. The incentive for clients to remain in the program is magnified by their desire to keep their family intact allowing the family to keep their housing, AFDC, Medi-Cal, and other support systems that would be stripped away with the removal of the children.

4. Describe how members of the target population helped prepared the application

NOFA changes page 12 states applicants are not required to answer this question.

5. Additional Organizations Participating In The FPC

We have successfully worked with 13 organizations in preparing for this grant. These agencies or organizations are fully committed and are in support of the FPC approach and concepts. The following organizations have a detailed description of the support they will providing, such support includes facilitating family stabilization; recreational programs; food, clothing, furniture, mentoring, toys, household needs; promote public awareness; facilitate programs, services; and develop resources to prevent child abuse and neglect. Additionally, working with other community resources will ensure continuity of alcohol, drugs and mental health treatment services; provide meth exposed children with medical and mental health screening; dental care; background checks and home evaluation for possible placement; removal from toxic chemical exposure; provide support at clients hearings, follow up services and ensure safety. For more detailed description of the support being offered see Appendix 1 for Letters of Support. These agencies include:

- Temecula Valley People Helping People
- Circle of Care
- Prevent Child Abuse Riverside
- Riverside County Sheriff's Drug Endangered Children Response Team.
- Mental Health Systems

County
- Temecula Interagency Council
- Local Congress support
- Riverside Defense Panel
- Administration Office of the Courts
- Housing Authority
- DACE
- County of Mental Health Substance Abuse Program
- Riverside Department of Public Social Services
- Attorney County Counsel
- St. Marthas
- Santa Rosa Del Valle
- WestEd
- Community Foundation

Family Preservation Court Team Roles and Responsibilities

The steering committee will take an active role in guiding the future course of the FPC Program. The committee members have attended six family drug court conferences over the past year. These conferences include the Permanency Practice Strategic Action Planning, Reclaiming our Families: Prevention & Intervention, La Bodega Training, and the 4th Annual Juvenile & Family Drug Court Training Conference. Steering committee members are members of the National Association of Drug Court Professionals. In addition, this committee will receive initial multi-disciplinary training and other training specific to the operation of drug court programs. The committee will convene monthly or at least quarterly to shape policy and operations. A Memorandum of Understanding between County of Mental Health, Department of Public Social Services, the Court, and community organizations has been prepared and discussed The following are committee member's roles and responsibilities:

Judge/Court: The Judge is the leader of the drug court team linking treatment to the criminal justice system. A judge's involvement in supervising relationships, monitoring of treatment services, increases the likelihood that a participant will remain in treatment and improves the chance for sobriety and law-abiding behavior. The court provides staff (e.g. clerk, bailiff, and court reporter) and facilities for weekly drug court sessions.

County Counsel: Reviews cases, files all necessary legal documents, participates in a coordinated strategy for responding to non-compliance issues, and agrees that a positive drug test or open court admission of drug possession will not result in the filing of additional charges based on that admission. The County Counsel makes decisions regarding the participants' continued enrollment in the program based on performance in treatment rather than on legal aspects of the case, barring additional criminal behavior.

Juvenile Defense: Reviews warrants, affidavits, charging documents and other relevant information, and reviews all program documents. Juvenile defense advises participant as to the nature and purpose of the drug court, the rules governing participation, consequences of abiding or failing to abide by the rules, and how participating or not participating in the drug court will affect his or her interests. In addition, juvenile defense explains all the rights that will be temporarily or permanently relinquished. He/she also gives advise on alternative courses of action, including legal and treatment alternatives.

Department of Mental Health/Substance Abuse Program: Provides early and continual assessment and reassessment of participants. They will provide treatment and counseling immediately available in a number of settings to include detoxification, acute residential, day treatment, outpatient, and sober living residences.

Mental Health Systems: Provides early and continual assessment and reassessment of participants and families. They will make special efforts to provide treatment programs that are comprehensive, gender specific, and culturally competent. They will provide specialized services considered for participants with co-occurring problems and mental health disorders. In addition is responsible for providing and implementing substance abuse and mental health treatment services.

Department of Public Social Services: The DPSS is the mandated provider of services to the family and will retain that role. Their role will be further designed to incorporate the "Family 2 Family" approach within their family maintenance voluntary (FMV) model and working closely with AFR and case management.

Law Enforcement: Will contribute programs in advisory capacity and assist with community outreach and the Drug Endangered Children program.

Housing Authority: Currently participating in a pilot program with the court, the Housing Authority provides housing vouchers to those clients recommended by the drug court judge who are performing at an exceptional level.

WestEd: Is an educational and social research, public non-profit organization that provides technical assistance in the development of programs that fosters resources from the community to provide sustainability to our recovery program and conducts evaluation research studies across various setting (i.e., schools, community, and drug courts). WestEd will be responsible for conducting and implementing all evaluation activities, including GPRA.

6. In-kind Contribution

In-kind contribution will be documented and reported in the annual reports, if awarded. Because of the support being provided to establish this process, our committee members and partners will be providing valuable time to ensure this project is implemented. We propose to document any in-kind contribution provided to this effort by documenting into a form given out to all members at every planning and implementation meeting and training.

7. Groundwork Completed to Date

We have held a series of meetings to date to address the planning of "Prefiled" population and the proposed program implementation. We held meetings with the Judicial Oversight Committee to present the ideas and get their support, partners helped to defined roles and responsibilities which led to the development of the memorandum of commitment, and shared ideas and examined policies that might hinder the implementation of the project. We also held a series of meetings with the County Department of Mental Health Substance Abuse Program, other interested treatment providers and Department of Public Social Services on defining the treatment service delivery to be provided to this targeted population. Providers discussed meeting the needs of clients in providing easier access to services, resolving the problem of

transportation, defining the needs of cultural relevant treatment and developing natural support groups, involving the children and family, and connecting with parents where ever they reside. In addition, we discussed data sharing and the purpose of evaluating the project. To date we have conducted two months of work in establishing buy-in, commitment, hope among our partners that have been challenged with drug-dependent parents, and opportunities to examine evidence base practices, and programs that will contribute valuable information to the field.

8. Potential Barriers To Proposed Project and Resolutions

In this case the barriers constitute the potential benefits of this new proposed process. The barriers include the changes in policies from the court, child welfare, and treatment services to provide overall equitable services for this new "Prefiling" population that continues to grow in our systems. However, such barriers also come with benefits to implementing this project, these include:

- **Preservation of the family unit in a substance abuse free environment.** Early and intense supervision by an interdisciplinary team will provide information services utilizing the existing dependency drug court program. In turn, this process will likely lessen the need to remove children from their custodial parent and cause separation from their siblings, thus reducing trauma to all of the family members.
- **Decreased and more manageable caseload in the dependency court.** Riverside County faces increased populations and no planned increased in the number of judicial resources. This AFR process will provide families with an effective substance abuse program, afford protection to children, and preserve the integrity of the family unit without additional judicial supervision.
- **Freedom from most of the statutory mandates relating to dependency law.** Information supervision programs such as this will eliminate the need for statutory review hearings, reports, and notice. Emphasis will be put on recovery and not the process.
- **Reduced costs to the County, State, and Federal.** The court will save money system–wide. We will examine cost saving in foster care or relative placement (current cost $500 per month), group home (current 5,613 per month) and court case processing (current cost $12,0000) including DPSS services. Results of documented cost savings for FPC implementation will be examined and used to justify the money going towards foster care and court costs to be reallocated for continued prevention efforts.

The resolution to these barriers is to collaboratively work together in a non-adversarial manner to increase interagency communication, document the progress, give timely feedback of the barriers and successes, and obtain technical assistance as problems begin and persist.

9. Secure Resources and Sustain the Project

The sustainability plan for the FPC includes the following strategies:

- The maintenance of a strong collaborative partnership (county, state and community) in which all members play a role in sustaining the programs through ongoing planning and development and sharing of resources
- The submission of grant proposals to government and private funding sources with an interest in keeping families together and eliminating the problems that tear them apart.

- The collection of program data that illustrates the effectiveness (including cost effectiveness) of program strategies.
- To develop a conduit for the public to donate goods, services, and funds for the families and children involved in our programs.

Section D: Staff and Organizational Experience

1. Riverside Superior Court's Capability and Experience in Providing Culturally relevant Services

Riverside Superior Court: Over the past 10 years, Riverside Superior Court has successfully implemented three adult criminal drug courts, one juvenile delinquency drug court, two family law drug courts, three juvenile dependency drug courts, and a mental health court. The diversity of the drug courts and the regions they have been operating in, demonstrate the court's willingness and their abilities to serve these populations. The court has taken the leadership role to assure that these programs get the attention they deserve and that the court's strategic plan is being met. The court is recognized as one of the most dynamic, progressive courts in the nation arising from its: quality of justice; ability to provide everyone with equal and convenient access to efficient, professional public services; appropriate dispute resolution mechanisms; implementation of innovative programs using modern technology; timely case management; safe environments where court users and personnel can conduct their business; staff known for expertise, and commitment to ensuring public trust and confidence in the judicial system.

Mental Health Systems (MHS*):* has provided successful substance abuse treatment and mental health services in San Diego County for over 26 years and in Riverside County for 9 years. MHS substance abuse treatment focuses on the treatment of entire family. For nearly a decade now, MHS has been providing gender-specific and culturally, linguistically, and age-appropriate treatment for women, infants and children. MHS greatly values cultural competence and requires it from all staff. A priority is placed in sustaining and hiring staff from diverse backgrounds, with a vast array of ethnicities and languages of origin represented within the agency. MHS provides compulsory cultural competency training for all staff. In addition, MHS has a Cultural Competency Resource Team that assesses and assists all MHS programs in achieving appropriate cultural diversity awareness, including linguistic, gender, cultural and ethnic specific skills, education and experience. In addition, the staff works closely with community partners and collaborators to develop materials and work processes that reflect the diversity of the communities and populations that they serve.

WestEd: is a non-profit educational research, development and service agency dedicated to improving education and other opportunities for children, youth, and adults. WestEd has 15 offices nationwide with over 400 professional, support and administrative staff. WestEd's Educational and Community Initiatives (ECI), the division that will evaluate this program has been serving the communities in southern California since 1994, first as a University of California, Riverside demonstration research office, and since 1999 as a WestEd affiliated office. ECI is under the Human Development Program (HDP) at WestEd. HDP is one of the foremost centers of research on youth drug use and risk behaviors in California. HDP conducts the statewide evaluation of the Safe and Drug Free School Program. All studies conducted by WestEd since the ECI office's inception are collaborative efforts with the community to address

the needs of hard to reach populations such as gang involved youth and children of substance abusing parents. WestEd also works with at-risk youth in the community furthering the depth of expertise in working with families struggling with substance abuse and treatment as well as treatment service providers. WestEd has a well-established history with Riverside County's social service agencies, courts, area school districts and community members. Table 6 provide detailed information about the key staff, the role, level of effort, community in which they reside and qualifications (See Section H for detailed experience and qualifications of staff).

Table 6. *Project Staff, Role, Level of Effort and Qualifications*

Project Staff	Role	Level of Effort	Qualifications
Pamela Miller, B.A Resides in Southwest	Project Director	10% FTE	Has over 8 years experience in implementing programs for four adult drug courts, two Juvenile Dependency Drug courts, Family law Substance Abuse Court, Unified Family Substance Abuse Court, and Mental Health Court in Riverside and San Diego County's.
Marsha D. Mathews, M.F.T., Resides in Southwest	Program Director	50% FTE	Has 16 years experience of working in an intensive day treatment program for substance abusing pregnant and parenting women and their children. Has served on Cultural Competence Committee for four years, and specializes in culturally specific substance abuse services to women.
Emma Gonzales-Anderson, M.S.W	Counselor	75% FTE	Has 15 years experience as a parent educator implementing parenting and substance abuse curriculum to the chemically dependent women. She is bilingual and bicultural in Spanish.
Kathleen Morgan, L.C.S.W.	Counselor	75% FTE	She has experience providing parenting education and child development training to professionals since 1989, and is a leader in the field of case management and parenting education.
Hugo Moreno, B.A.,	Counselor	75% FTE	Has 5 years experience in facilitating counseling groups for Spanish speaking clients. He is bilingual/bicultural, and has three years experience working in substance abuse treatment.
Veronica Harris, B.A. Residing in Riverside Metro	Case manager	100% FTE	Has 6 years of experience in providing family case management services, to high risk children, youth and adults faced with substance abuse related problems in the Riverside area. She is bilingual/bicultural in Spanish.
Esperanza Abejon, B.A. Resides in East Indio and bordering Southwest	Case manager	100% FTE	Has 5 years experience in conducting case management and in home service support for DPSS clients faced with allegations of child abuse. She is bilingual/bicultural in Spanish.
Dr. Thomas Hanson , Ph.D.	Evaluator	100% FTE	Has over 13 years of experience and training in statistics and research methods. His primary areas of research include poverty, health and health behavior, and research methods. Expertise in most aspects of study design and implementation. Has over 6 years experience in analyzing GPRA measures.
Dae Lee, M.S.	Evaluator Assistant	60% FTE	Has 2 years experience conducting research and evaluation in drug court. Has experienced with Riverside Mental Health MIS. Has 2 years experience

Project Staff	Role	Level of Effort	Qualifications
			in administering GPRA measures.
Cecilia Mutia, M.A Resides in Southwest	Technical Assistant and Consultant	20% FTE	Has over 14 years experience in conducting work under CSAP funded programs and evaluations. She has directed numerous CSAP research programs and serving as a specialist on cultural competency, is knowledgeable about working with immigrant families to reduce substance use. She is bilingual/bicultural in Spanish.

3. Resources Available, Facilities, Equipment and Other Supports

Riverside Superior Court. The Riverside Superior Court will allocate space for the initial assessment of clients coming directly out of court, court rooms in each location for the teams to meet and drug court hearings and graduations to take place, the ability to collect and process data for the program, equipment and staff to produce the required reports, and confidentiality and security for our clients.

The Riverside County Substance Abuse Program (RCSAP). RCSAP facilities are equipped and accessible to everyone receiving treatment and other services. Facilities include large rooms with a capacity of 70 to 150 people. All rooms are equipped with billboards to write on, tables, chairs, and TV/video monitors. RCSAP's child care room is divided into two sections one side for infants and the other for toddlers. The infant section is equipped with at least 6 cribs and an area for infants to play. The toddler's section has a play area and a sitting area for activities. The child care room has access to children restrooms and changing tables. The county is required by the Child Care Licensing to have the room and toys sanitized when used by children. Training of this protocol is also provided along with emergency evacuation training.

Mental Health System: In an effort to expand services into the three regions, MHS will locate facilities close to the courts for our intensified one stop treatment. MHS has vast experience in expanding programs throughout the state. Once awarded the program, MHS will begin the move in process into buildings that we had previously identified as possible implementation sites. The Quality Assurance department contacts the State so we can move forward in getting A.O.D. and/or Medi-Cal certified. All of the buildings we will utilize meet the A.D.A. requirements. At the same time, we will hire staff or promote existing staff from other MHS programs and they will receive any special training they might need along with making up new clients charts and getting familiar with the curriculum that we would be using. In determining a building we always make sure it is close to the courts and it has bus accessibility for our clients. The treatment providers will have all necessary equipment and furniture to provide the program with data, confidentiality, and security for our clients.

WestEd Riverside Office. The WestEd - ECI office in Riverside is over 1,300 square feet and has seven offices with a large workroom. The office has a kitchen area and conference room. The office is equipped with 14 personal computers, a high capacity network and server, three printers and one copier. A large data entry room with workstations is also equipped with additional workspace and filing cabinets. Mobile equipment such as cell phones, lap-top computers, and flipcharts/easels are accessible to staff when traveling to site locations.

Section E: Evaluation and Data

Methodology

To successfully evaluate the performance of the Family Preservation Court Program, we will document the implementation and development of the program using a comprehensive process and outcome evaluation research design (See Table 7 for Process and Outcome Evaluation Research Questions and description of study materials in Appendix 2). A repeated pre- and post-measures design will be used to assess the effectiveness of the program. A total of 360 individual clients will be served by the FPC program over three years (120 clients for each year). With an average children size of 3.5 per individuals, we will service a total of approximately 1620 children and adults.

Process Evaluation

The purpose of process evaluation is to document the development and implementation of a comprehensive court-based family preservation program utilizing diverse resources from county mental health, substance abuse, social services, judicial services, and community-based organizations. As such, it is imperative to describe what happens during this implementation phase as well as identify any changes made to the program since its inception. More specifically, we will answer:

1) How closely is the structure and implementation of FPC program matching the proposed plan? (a) By describing the structure and implementation of the program; and (b) by describing how the implementation is meeting the proposed plan of FPC program;
2) What are the obstacles, barriers, and solutions to the implementation and effectiveness of the program? (a) By detecting barriers that have led to departures from the proposed; and (b) by tracking modifications and consequences due to redirecting the intervention; and
3) What programs and procedures were modified to improve the effectiveness of the program? (a) By tracking agencies and programs which have directly impacted client and family welfare and (b) by monitoring the effects of the modified interventions.

The major focus of this evaluation will be qualitative in nature, although we will use quantitative information where appropriate (e.g., client satisfaction surveys, committee fidelity surveys, case management fidelity surveys, dosage). The process evaluation is designed to measure the evolving contexts of the development of the program and the effects of changes in experience, re-staffing, and/or re-budgeting on the program. This will be accomplished through staff and client interviews and surveys, administrative data, debriefings, management logs, notes to the file, meeting minutes, and project component records.

Outcome Evaluation

The main purpose of the outcome evaluation is to determine the effectiveness and impact of the Family Preservation Court Program on the welfare of parents, their children, and families. By providing participants with intensive court case treatment and culturally sensitive services before their child(ren) are taken away, this program endeavors to strengthen and support the family unit by altering parents' previous drug and/or alcohol dependent lifestyles while simultaneously eliminating the time a child spends in the foster care system. More specifically, we will answer:

1) What individual factors are attributable to the clients' success or failure in the program? (a) By measuring retention rates (e.g., number of months in the program); (b) by measuring relapse rates (e.g., number of times reporting substance use after enrolling in our program, drug test results); (c) by obtaining information on the clients' personal social network (e.g., number of people who are currently supporting the client and the family); and (d) by measuring the individual differences clients bring into the program (e.g., demographic information, educational background, employment background, previous mental diagnosis, number of years of substance abuse, number of child already placed out-of-home, and more); and
2) What program factors are critical components of clients' performance? (a) By measuring the number of programs (e.g., Nurturing Program, Life Skills Workshop, Child Development, School Readiness Workshop) clients actually participate in (e.g., number of days present); (b) by computing the cost per client; (c) by measuring the timeliness of processing clients into our program (e.g., counting number of days from contacts with case manager to first court appearance); and (d) by measuring the quality and fidelity of services clients receive as a direct result of participating in our program (e.g., fidelity check will be measured by conducting client focus groups and collecting client surveys); and
3) What are the benefits for clients as a result of participating in FPC program? (a) By measuring the timeliness of the reunification process (e.g., for parent whose children are taken away, count the number of days children are away from the parents); and (b) by assessing the number of additional services clients receive after completion of our program (during aftercare).

A repeated measures design with no comparison group will be used to measure the impact of the program. Each year 120 clients referred by DPSS Central Unit will be served. Clients will complete outcome measures at three different times at intake, at 6-months, and at 12-months (see description below).

Outcome Measures

To effectively track client outcome information delineated in the outcome evaluation section above, case managers will maintain an established on-line database system named Transitions by Loryx. This is the database currently being used by the Riverside Dependence Recovery Drug Court, Adult Drug Court, and Family Drug Court to track their clients and the services that they receive. As new clients enter the FPC Program, case managers will open a case by assigning an identification number and entering the initial screening information. This system makes possible for the multiple key players (e.g., DPSS, Court, Case managers, Mental health) to input and view client outcome information. In addition to information collected at the time clients are screened, further data will be collected from self-report and administrative sources.

Additional outcome information will be collected from self-report adult outcome questionnaires including:

a. Government Performance and Result Act (GPRA) Questionnaire, which includes measures of 30-day ATOD use, perceived harm from ATOD use, and disapproval of use;
b. Addiction Severity Index (ASI), a well-known structured clinical research interview created to measure problem severity in seven areas commonly affected among substance abusers: medical condition, employment, drug use, alcohol use, illegal activity, family relations, and psychiatric conditions (McLellan, Kushner, Metzger, & Peters, 1992). The ASI is collected by Mental Health clinicians and the data will be submitted to the evaluator;

c. Beck Depression Inventory (BDI), a well-known instrument that measures the presence and degree of depression, (Beck & Bemesderfer, 1974);
d. Perceived Stress Scale (PSS) which measures the subjective perception of how stressed clients have been in the past month (Cohen, Kamarck, & Mermelstein, 1983);
e. Adult Adolescent Parenting Inventory II (AAPI-II) which assesses parenting and child rearing attitudes of adults in five domains: expectations of children, empathy towards children's needs, use of corporal punishment as a means of discipline, parent-child role responsibilities, and children's power and independence; and
f. Readiness to Change Questionnaire which taps into clients' willingness to change their behavior problems.

The ASI, BDI, PSS, AAPI-II, and Readiness to Change Questionnaire have been used in evaluation research and have been found to have good psychometric properties across different minority groups and for both men and women, as well as for adults who are alcohol and/or drug dependent (Beck & Bemesderfer 1974; Cohen, Kamarck, & Mermelstein 1983; McLellan, Luborsky, Cacciola, Griffith, Evans, Barr, & O'Brien 1983; Lutenbacher, 2001; Rodriguez-Martos, Rubio, Auba, Santo-Domingo, Torralba, & Campillo, 2000).

Administrative data will be collected from participating agents or agencies including, but not limited to, the Family Preservation Court, the Judge, the Department of Public Social Services, Case Managers, the Department of Mental Health and Substance Abuse Program, participating drug treatment clinics, and participating community-based organizations. Adult measures from administrative sources include: (1) toxicology screening results (randomly every 2 months), (2) retention in substance abuse treatment, and (3) functional status (e.g., employment, arrests, and housing). All of the child outcome measures come from administrative sources. These measures include: (1) subsequent reports of child abuse/neglect and substantiations of reports, (2) progress reports and case notes, and (3) number of referrals to mental health services.

Procedures for Obtaining Outcome Measures

Prior to enrollment in the Family Preservation Court (FPC) Program, the case managers at each site will identify potential clients based on referrals from the DPSS central unit and take the initial screening. If clients meet the minimum requirement, the case managers will instruct the clients to set up an appointment with the Riverside County Substance Abuse Program (RCSAP). The case managers present information about potential clients to the steering committee members where they make recommendations on whether to accept the client into the program. The final decision on whether to accept a client rests with the presiding Judge. Once the Judge and the committee members agree to accept the client into the FPC, the case managers contacts the client and sets the appointment to appear before the court. If the client chooses to participate in the FPC, the client signs a contract for voluntary entry into the program.
The case managers will provide information about the evaluation and obtain consent from those willing to participate in the evaluation component. In addition, the case managers will obtain a tracking form consisting of client location information (i.e., client address, family address, and friend address) and names and birth dates of the clients' children. The Evaluator from WestEd will obtain client information from the case managers on a weekly basis and contact the clients to schedule the collection of baseline measures (i.e., GPRA, BDI, and PSS) by a Questionnaire Assistant from WestEd. Most of these appointments will take place at the court; however, the clients can suggest an alternative meeting place. In order to better facilitate the collection of

follow-up data, the Questionnaire Assistants will call clients in the FPC on a monthly basis to maintain contact and update information.

Since the ASI is administered by the Riverside County Substance Abuse Program (RCSAP) at baseline and 6 months, we will request these data from RCSAP. Similar procedures will be used to collect 6-month and 12-month follow-up data. As the time approaches for the follow-up, the Evaluator will contact the client to schedule the follow-up appointment. The Questionnaire Assistants will collect the in-treatment (6-months) and follow-up (12 months) data on the outcome measures specified above (i.e., GPRA, BDI, PSS and client satisfaction) after clients attend court appointed hearings at the drug court. These measures take approximately 40 minutes to complete and can be self-administered or, if literacy or language is an issue, Questionnaire Assistants can assist in survey completion.

The Adult-Adolescent Parenting Inventory II and the Readiness to Change scale will be administered by the Questionnaire Assistants before and after participating in the Nurturing Program. The purpose of these two questionnaires is to measure the effectiveness of the nurturing program on clients' attitudes. Case managers will provide a list of clients who are ready to participate in the Nurturing Program to the Evaluator. Data points will be monitored by the Evaluator and contacts will be made with the clients and FPC staff to ensure the timely collection of all data. Client, facilitator, and counselor process surveys are collected at designated intervals. These protocols are followed to monitor the accuracy of the data and timely completion of evaluation tasks. In accordance with human participants in research, an Independent Review Board will approve all final protocols to ensure protection of participants.

Data Analyses

In order to answer the process questions posed above, we will conduct descriptive analyses on a quarterly basis to inform and give feedback to the program staff and the committee members. Descriptive analyses will identify the process of implementation, detect barriers, as well as solutions, to implementation, and describe specific changes made to carry out the implementation. Additionally, Loryx Transitions database has pre-defined reports which can be generated by specifying certain indicators (e.g., number of active clients in complete compliance). These reports will be generated and distributed to the committee team.

Several statistical methods will be utilized to assess the outcome variables (such as t-tests, Analysis of Covariance, Survival Analyses). Paired-sample t tests will be conducted to perform simple within comparisons between different outcome variables. Moreover, in order to measure the changes in clients' outcome measures after accounting for individual differences, a repeated Analysis of Covariance (ANCOVA) will be conducted on outcome variables by time (intake, 6 month, and 12 month). Survival analysis will be conducted in order to determine which individual and program factors are important in determining clients' success or failure in the program. This analysis takes into account the length of time clients participate in the FPC program and whether they successfully complete the program or not with variables that may be predictive of the this success or failure (e.g., persistent relapse, age, or type of drugs clients abuse).

This project has the capacity to collect data for the Government Performance and Results Act of 1993 (GPRA) as outlined above. The GPRA tool will be used with adults and the data will be forwarded to the responsible federal agency. The evaluator will ensure full compliance with this regulation. All of the necessary agencies and staff participating in the project will be available to participate in all technical assistance and training activities designed to support

GPRA and other evaluation requirements. The local process and outcome analyses described above are fully integrated with GPRA requirements.

Cost Per Person

The proposed treatment services cost per person is $2,667 which is under the range proposed by SAMHSA. There are other cost incurred that are not identified, nor considered in the formula. We propose to document all incurred additional cost of treatment services offered to the client. The cost per person was calculated using SAMHSA/CSAT formal for computing cost per person. We are requesting for a total of $400,000 per year, took the .2 allowance for GPRA which gave us a total of $320,000 for treatment services. The amount of $320,000 was divided by 120 clients in a year. The total cost per person per year is $2,667.